DHS-DMH Joint Retreat on Mental Health Services for Healthy Way LA Enrollees (May 29, 2012)		Community Partners	Legal Entities	Directly-Operated
QUESTIONS & ANSWERS				
1.	**Q: What do you do if the staff who is trained in MHIP does not speak the language the client needs? You can't use the case manager?** A: Staff would need to use the HWLA Partnership Listing on the DMH website and/or contact the DMH Service Area Navigator to identify another mental health services provider with the language capability the clients needs.	√	√	√
2.	**Q: In a prior meeting for Older Adult PEI Providers it was identified that we could use the "one-time" funding for presentations about PEI services to the community, which may include HWLA information. Is this the same understanding from the DMH Office of Integrated Care? If so, would we invoice for these presentations?** A: The DMH Office of Integrated Care does not reimburse contract providers for "community training" on HWLA or Tier 2 services. The allowable expenditures for PEI one-time funds are described in the 1115 Waiver Demonstration Project Agreement and attached invoice.	√	√	
3.	**Q: When will DMH alter contracts for Legal Entities to fund Tier 1 referrals?** A: When Tier 1 funding becomes available to DMH.		√	
4.	**Q: Is DMH going to encourage/facilitate partners' participation in client care?** A: DMH strongly encourages health and mental health agencies to closely coordinate care of shared patients. This is an expectation of the MHIP model. An MOU between partner agencies is one method of clarifying the roles and responsibilities of each partner so that care may be coordinated.	√	√	√
5.	**Q: Are the PHQ and GAD measures available in other languages?** A: Yes, they can be found at http://phqscreeners.com.	√	√	√
6.	**Q: What is the status of the registry?** A: DMH is not moving forward with the registry, but will be looking at something comparable in the future to assist in the exchange of vital information between the care team, (i.e., PCP, care manager, and consulting psychiatrist). In the immediate future, we will be piloting the collection of basic demographic and screening tool scores with several agencies providing HWLA MHIP services. Additional information will be provided as it becomes available.	√	√	√
7.	**Q: Does the referral form have to be sent via RPS or fax?** A: If the DHS RPS is used to send the referral, the referral form should be scanned and attached to the referral in the RPS. If the RPS is not used, the referral form should be faxed directly to the mental health partner agency.	√		
8.	**Q: If we use the RPS, how can we make sure that the referral goes directly to our partner?** A: The DHS Central Referral Unit (CRU) will detect the referral in the RPS and forward it to the partner of record.	√		

9.	**Q: How often can a client be referred from DHS to mental health for MHIP services? Or, how many times?** A: The patient/client may return to access another 6-10 week course of MHIP/PST if they meet medical necessity and if they are returning for a separate reason (different issue/problem/topic) and not because they didn't respond well to the original treatment. As long as the above criteria are met there is no specific number of times someone can be referred back for MHIP services; however, the preferred treatment modality (PST) focuses on building the client's problem-solving skills, which would decrease the likelihood of them returning to treatment.	√	√	√
10.	**Q: How do we (Community Partner) get the Referral Response form? Is it mailed? Online under the patient's account?** A: The Referral Response form can be mailed or faxed directly to the referring Primary Care Provider or can be faxed to the DHS CRU for forwarding to the referring PCP.	√	√	√
11.	**Q: Should the mental health provider send another mental health referral response form to the PCP when transferring Tier 2 clients to Tier 1?** **A:** A Referral Response form is not required when the mental health provider changes the patient's level of care from Tier 2 to Tier 1. The provider of Tier 2 services would note the transfer in the medical record and may provide a copy of the discharge note with transfer information to the PCP.	√	√	√
12.	**Q: Are medications prescribed or recommended by DMH?** A: Within the MHIP model of care, the PCP oversees the overall care of the patient/client, including prescribing psychotropic medications. The consulting psychiatrist serves to provide psychotropic medication recommendations/consultations to the PCP when needed.	√	√	√
13.	**Q: How many referral response forms should Community Partners expect to receive from DMH providers?** A: One for every patient referred.	√	√	√
14.	**Q: How will Community Partners know that treatment has concluded?** A: The treating mental health provider is expected to send a brief discharge summary to the referring primary care provider at the conclusion of treatment (primarily for short-term Tier 2 referrals). This may be a copy of the Mental Health Discharge Summary and any aftercare plans as appropriate.	√	√	√
15.	**Q: Will Community Partners receive periodic reports of our referrals?** A: A Community Partner should receive at least two reports from the mental health provider, an initial Referral Response form following the client's assessment and a Discharge Summary when treatment has concluded (primarily for short-term Tier 2 referrals). Ideally, there is an ongoing collaboration between primary care and mental health providers regarding shared patients/clients who have co-occurring physical and mental health conditions.	√	√	√

16.	**Q: As a Legal Entity provider for the Tier 2 HWLA population, would Adjustment D/O diagnosis be considered an included diagnosis?** A: Yes.		√	
17.	**Q: As a Legal Entity provider we anticipate not utilizing the entire allocation for the consulting psychiatrist services (manual invoice). In the next fiscal year can any of these funds be shifted to direct services for HWLA clients?** A: No, DMH would increase the provider's allocation in the direct services category if warranted and to the extent funds are available.		√	
18.	**Q: As a Legal Entity provider, if we have a HWLA client that receives retroactive Medi-Cal the procedure is to 'back out' units of services provided under HWLA and reclaim those services to Adult or Older Adult PEI as an IS Plan, correct?** A: Yes, that is correct.		√	
19.	**Q: In the above scenario, as a Legal Entity provider will we receive credit for services provided while the client was identified as HWLA?** A: Yes.		√	
20.	**Q: How will e-consult play out with this HWLA/DMH program for Community Partners participating in it with LA Care and DHS?** A: eConsult is a secure, web-based platform that facilitates clinical dialogue between Primary Care Providers (PCPs) and Specialists for the purpose of providing timely and coordinated specialty care services for patients with specialty care needs. Over the next 1-2 years we expect that most, if not all, non-urgent outpatient specialty care will begin with eConsult. It will facilitate: • Dialogue between Primary Care Providers (MD, NP, PA) and Specialty Reviewers around the needs of a specific patient. We anticipate that this dialogue will, in many cases, satisfy the specialty within their medical home. eConsult alone can replace a face-to-face visit in 25-50% of cases. • A better understanding of why a specialty care referral was made including and allowing the first specialty visit to be a definitive one. Published data show that eConsult improves by 50-75% the ability of a specialist to understand why a patient has been referred to them and for what. • The ability to offer "co-management support" to PCPs caring for patients with complex, chronic conditions while allowing the patient to remain in a culturally and linguistically optimal, geographically convenient medical home. The next phase of e-Consult will include a DMH directly-operated clinic; the plan is to eventually include all DMH and Legal Entity mental health providers.	√	√	√

21.	**Q: What is the DHS doing to encourage health care – FQHCs – get on board with co-location and more fully understand what HWLA is?** A: DHS is working with all Community Partners to ensure that mental health services are either being provided on-site or that patients are appropriately referred to a mental health agency that can provide the service. It is absolutely essential that Community Partners understand mental health access is a required component and benefit under the HWLA program. However, understanding this fact is not enough – clinics must also implement. Therefore, DHS has been outreaching to each and every Community Partner to try to facilitate this relationship with a DMH or Legal Entity provider, with varying degrees of success for different clinics. DHS intends to continue to work with clinics until we have succeeded.	√		
22.	**Q: Why do Community Partners have to submit their mental health consult/referral over RPS when we have a system of referral set-up with our DMH Tier 1 and 2 partner (LE)? Why can't DHS get information from DMH rather than making Community Partners do more work?** A: For tracking purposes, DHS would prefer that Community Partners use RPS for referrals to specialty mental health services as they do with all other referrals to specialty services. However, if a Community Partner has an effective system in place to transmit referrals to its DMH partner timely, it is acceptable to send the referrals directly to the DMH partner without going through RPS.	√		